STURDY
MEMORIAL HOSPITAL

May 24, 2012

Mr. Áron Boros, Commissioner
Executive Office of Health and Human Services
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Dear Commissioner Boros,

This letter is in response to your letter to Linda J. Shyavitz, dated May 9, 2012, in which the Division of Health Care Finance and Policy and the Massachusetts Attorney General requested that Sturdy Memorial Hospital provide written responses to questions regarding current trends in healthcare costs. As requested in your letter, we are sending our response electronically.

If you have any questions, please call me at (508) 236-8155. Thank You.

Sincerely,

Joseph F. X. Casey
Treasurer & CFO

211 Park Street, P.O. Box 2963, Attleboro, Massachusetts 02703-0963 Tel. 508-222-5200 Fax 508-236-7909
www.sturdymemorial.org

Written Testimony in Response to DHCFP Questions in Exhibit B

Trends in Premiums and Costs

1.) After reviewing the preliminary reports, please provide commentary on any findings that differ from your organizations experience. Please explain the potential reasons for any differences.

The report observes that premiums and claims expenditures continue to grow faster than inflation. Between 2008 and 2010, adjusted premiums increased 11% for large groups (more for small and mid-sized groups). Our hospital reimbursement rates, however, have increased by no more than inflation during that time period, and reimbursement rates for our physicians, on average, have increased at rates below inflation.

The report also provides evidence that group purchasers are selecting insurance packages with fewer benefits and higher cost sharing requirements, know as "benefit buy-down." This may reduce access to care or increase out-of-pocket expenditures. We recently completed an internal analysis that supports this observation. We compared the patient liability, for commercially insured patients, relative to the total liability (insurance liability and patient liability combined). The patient liability portion increased from 5% of the total liability in 2006 to 9% of the total liability in 2011. We further observed that in 2006, patients paid 78% of their liability, but that percentage has dropped to just 63% in 2011. This has led to a rapid increase in bad debts over that time period, almost wiping out the reduction in self pay bad debt achieved as a result of healthcare reform.

The report also highlights significant variation in TME by physician group. We looked at the variation in TME for our physician group across the three largest payers. Since our contracted rates are similar for the three payers, and our physicians do not make clinical decisions about patients based on their insurance, we would expect the TMEs to be similar. According to the report, they are not. Our physician group TME varies between approximately $400 and $440. Additionally, when compared to other provider groups, our TME is at the Blue Cross median, above the median for Tufts and well above the median for HPHC. One contributing factor to the higher Tufts and HPHC TME amounts relative to Blue Cross may be related to our proximity to Rhode Island, where Blue Cross may have negotiated lower reimbursement rates.

Finally, the report mentions that among the different payers there was no consistent relationship between the TME of the managed or non-managed population, with or with out the health status adjustment. It was postulated that, "this may reflect the imperfect nature of health status adjusters' ability to explain variation in TME, or limitations of current managed care structures to support PCPs in efficiently coordinating care for their total patient population." We would add that this may also be attributable to the significant infrastructure or other payment amounts that are paid to some provider groups to manage their patient populations under a global budget. These payments would increase the TME of the managed population and may outweigh any associated cost savings those groups achieve.

2.) **What specific actions has your organization taken to reduce the cost of services? Please also describe what impact, if any, these strategies have had on service quality and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?**

The hospital has a long history of ensuring that we fulfill a component of our Statement of Purpose: "to provide its own services as cost efficiently as possible."

Among the actions we take are the following. This list is a partial list only.

- For over twenty years, we have flexed nursing staff <u>per shift</u> to match the actual volume on the unit.
- For over fifteen years, we have similarly flexed ancillary staff <u>per week</u> to match current volume trends.
- An active Value Analysis Committee and an OR Value Analysis Committee reviews, trials if necessary, and approves or rejects all medical/surgical supplies and instrumentation prior to purchase to ensure quality and cost effectiveness.
- We provide a discriminatingly implemented, conservative, hospital-wide merit system for employee wage increases rather than cost of living increases or step increases.
- Routine (annual or every other year) reviews of multi-hospital comparisons of individual department costs per unit of service are conducted by hospital staff, Yankee Alliance, or private consultants. Management action is taken to reduce costs in any department where we are an outlier or even at the high end of the range.
- We coordinate efforts with other providers in the community to ensure our patients get the services they need without duplicating the efforts (and the expenses) of others. As one example, we contract with a community psychiatric hospital to be certain that our medical/surgical inpatients get the psychiatric services they need while hospitalized here.
- Multiple clinically led initiatives are conducted to improve the quality of care, often leading to reduced unnecessary utilization of health care services or delivery of those services in a more cost effective setting: For example:
  - Our primary care physicians have continued a campaign, initiated in January 2010, to educate their patients to call them for any non emergent problem before going to the emergency room. ECC (emergency care center) utilization initially dropped 7% for the population about whom we received insurance claim data.
  - A length of stay initiative, begun approximately one year ago, and led by the hospital CFO, has resulted in a .3 day (or 7.3%) decline in our average length of stay. The focus was on clinical improvements, for example, better

communication among nurses, physicians, physical therapists and patients, which resulted in patients ambulating sooner and more frequently and therefore being ready for discharge sooner.

- Follow-up appointments, for patients to be seen within ten days of discharge, are made with the appropriate physician for all inpatients prior to discharge. This improves the continuity of care and helps reduce the potential for hospital readmissions.
- We continue our involvement with the Institute for Healthcare Improvement (IHI) project to prevent avoidable hospital readmissions. Our clinical focus has been on Congestive Heart Failure patients, particularly patients' medication and dietary compliance.
- We are in the midst of a comprehensive multi-year educational campaign against hospital acquired and community acquired antibiotic resistant organisms. The hospital portion focuses on reducing transmission of bacteria through proper hand washing and the community program is aimed at reducing the unnecessary use of antibiotics.
- Our ECC physicians routinely manage low risk chest pain rule ins/outs in the emergency room, rather than admitting them to observations status, which is clinically appropriate and less costly.
- In order to reduce unnecessary workups and treatments in the Emergency Room, we have worked with the nursing homes in our community to better coordinate care for those patients by standardizing the clinical information required when nursing homes send their patients to our emergency room. A standardized form is utilized and compliance to the process is monitored in real time.
- We have an initiative to move IV drugs to the oral form when appropriate. This reduces the need for intravenous catheters and the associated complications of infusions related adverse events. Targeted medications include those that are minimally disruptive to the treatment course and have similar bioavailability to the IV form. The program results in a decrease in patient complications, and the associated cost of those treating those complications, as well as cost savings from the lower cost drugs.

Our primary responsibility is to provide optimum quality patient care. The clinically led initiatives are only implemented if the cost reductions are achieved only as a consequence of quality being maintained or improved.

- The hospital and our affiliated physician group have made significant investments in electronic medical records which will improve the quality of healthcare as well contribute to lower costs.

  - The hospital electronic medical record: Currently 96% of our physician orders (excluding anesthesia, which is in progress) are entered electronically thereby eliminating potential errors caused by illegible handwriting. Pharmaceutical orders are screened for potential interactions with other drugs and patient allergies. Mediation Reconciliation is done electronically in all settings. Bar coding is utilized when administering medications to make sure the right medication at the right dose is administered to the right patient. The Medication Reconciliation system in the emergency room is integrated with Dr. First which allows the triage nurse to see what medications the patient may be on according to the offsite participating pharmacy records. E-prescribing is utilized for patients discharged from the emergency room. The hospital EMR sends laboratory and imaging results, as well as discharge summaries and emergency room notes, to the Sturdy Memorial Associates (see below) electronic medical record. This results in improved care coordination which ultimately results in better patient care and lower costs. The hospital qualified for the federal stimulus money in 2011 based on the implementation and extensive use of its EMR.

- The group practice medical record: Sturdy Memorial Associates is a multi-specialty group practice consisting of approximately 59 physicians of which 32 are primary care physicians. All the physicians in the practice utilize a fully integrated, comprehensive, electronic medical record. Complete patient history is available to all physicians within the group resulting in improved coordination of care with no duplication of services (e.g. lab testing). As noted above, the hospital and physician group share lab and imaging results, as well as discharge summaries and emergency room notes, through the electronic medical record. All SMA primary care physicians have been certified as NCQA level 3 patient centered medical homes. For a complete description of the NCQA standards of care, see our answer to question 5 below.

3.) When calculating Total Medical Expense (TME), we found a wide variation in health-status adjusted TME by provider group and that a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please share your organization's reaction to these findings.

Review of the graphs published in the Report on Massachusetts Health Care Cost Trends Premiums and Expenditures shows that some of the largest physician groups in the state fall in the most expensive TME quartiles. This is especially true for Massachusetts Blue Cross (MBC) which is the largest private insurer. At least two of those large groups are known to have negotiated lucrative MBC AQC contracts. It is also known that the largest physician group in the commonwealth negotiated good rates for its affiliated physicians. It is therefore, not surprising that a large portion of patient volume is clustered in the most expensive quartiles.

4.) Please explain the main factors for any changes in TME that your organization had experienced. What specific efforts has your organization made to lower or reduce the growth in TME? What has been the result of such efforts?

It was difficult to distinguish cost savings, as described in Question 2 of this document, from efforts to lower TME, as required in this question. We have therefore answered as a single, combined response in Question 2.

Health System Integration

5) How ready does your organization feel it is to join, affiliate with, or become and Accountable Care Organization? Please explain.

We currently have no plans to become or join an Accountable Care Organization. We made the investments in our affiliated group practice to not only acquire a sophisticated physician office EMR, but also to structure our primary care practices to meet all of the challenging requirements for recognition by the National Committee for Quality Assurance (NCQA) as a Level 3, Patient-Centered Medical Home (PCMH). The NCQA requirements are comprehensive and rigorous. We aimed for, and achieved, level 3 designation because we thought that success at the highest level was essential to participate fully in the Commonwealth's efforts to restructure care. Further, because SMA primary care practices function as PCMH's, these practices ensure the integration and coordination of care among all physicians on our medical staff and with the hospital. There are few PCMHs in Massachusetts that have achieved level 3 designation. We chose this approach to structuring our care delivery system not only because the features of PCMHs mirror those that public officials and agencies in the Commonwealth are promoting, but because this care delivery model best fits our medical staff size and the number of patients in our practices.

a) Is your organization participating in the Medicare Shared Savings Program?
No.

b) If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one?
As stated above, we have no current plan to form or join an ACO because the "supports" such as information systems, actuarial fees, governance and administrative overhead, to name a few, would likely outweigh the potential cost savings in our community. As reported in the September 8, 2011, New England Journal of Medicine, the BCBS payments to AQC groups including bonuses for quality, information technology, staffing and other needs, are likely to have exceeded the estimated savings in year 1 of that contract.

6) Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, patient outcomes and your organization's performance?

We are in the first year of two shared savings type contracts, so we do not yet know what impact they may have. Most of the area PCPs are now Level 3 designated Patient Centered Medical Homes which we believe will result in lower cost as care is better managed.

7) Please comment on how your organization is developing formal arrangements or affiliations with other health care providers to provide care under global contracts or other alternative payment methods.

As mentioned previously, we have invested significant resources in information systems which allow shared information between the hospital and our affiliated multi-specialty physician group as well as electronic access for patients to view their medical information. In addition, HIE technology we have acquired and are currently installing will allow other area providers access to a shared electronic medical record. Also, as noted in our response to Question 5, our primary care physicians have all been designated as level 3 patient-centered medical homes by NCQA. We are committed to participating in alternative payment arrangements designed around the patient-centered medical home model.

8) What have been the effects of the recent proliferation of limited or tiered network plans on your organization, with regard to how you evaluate performance internally and patient access to care?

It is difficult to gauge the effect of tiered networks. Our hospital volume, in general, was lower in FY 2011 compared to FY 2010, but based on the extensive inpatient and outpatient Massachusettts hospital surveys that we participate in, volume appears to have declined at most hospitals. It is more likely that the poor economy drove most of the decline. We are a tier 1 provider for Tufts and a tier 3 provider for Blue Cross and HPHC. There are no significant changes in volume among the payers.

In terms of limited networks, we do have some information to share. During this past year we were not participating in CeltiCare or Network Health for Commonwealth Care members. We had tried to contract with both providers last year when it became clear that they would be the only insurers for Type I Commonwealth Care members (effective July 1, 2011), but both insurers chose to limit their networks and exclude us. This resulted in patients having to change physicians and travel significant distances for non-emergent hospital care. Our emergency room visits, for Celti-Care and Network Health members, increased from an average of 10 per month prior to the July 1st date, to almost 50 per month by September. We think this means patients still chose to get their care locally, albeit in a more expensive setting. Network Health has subsequently contracted with us effective July 1, 2012.

"Smart tiering" is a new concept that has garnered some attention recently. It is aimed at tiering providers at the service level based on the cost of each specific, or type of, service. Under "smart tiering," there would be financially incentives for patients to go to different providers for different services. We are concerned that this concept is contrary to "managed care." Electronic medical records are intended to capture patient health information so that it is available the providers participating in the management of that patients care. The unintended consequences of smart tiering may be missed results or duplicative services.

9) Given the proliferation of risk contracting, to what extent is your organization participating in global contracts that include "atypical" healthcare providers (e.g., behavioral health, oral health, home health care, etc.)? If your organization participates in a risk contract, how are supporting services, such as behavioral health and home health care, addressed?

While we have two shared savings contracts, they are new and data sharing has been non-existent. Without utilization information it is difficult to formulate a strategy involving the entire continuum of care. Based on some preliminary cost data from Medicare, it is possible that there is over utilization of SNF services in our area. We have yet been unable to get sufficient utilization or comparative data to substantiate this idea or to create any strategies to address it.

Health Care Quality

10) Are there specific areas of care for which you believe there are critical gaps in quality measurement?

The sophistication and availability of comparative patient data available to providers to help them best manage patient care is grossly inadequate. The insurance companies have significant data in their claims databases, but do not use it to assist providers in identifying areas where there may be opportunities to improve patient care and/or lower costs. Following are excerpts from a letter we recently sent to several of our state representatives suggesting some clinical quality issues that could be identified from health insurance claims data:

a) COPD readmission rates – Variation in readmission rates may be the result of good programs or practices of which others should be aware.
b) Renal failure in diabetics as captured by discharge diagnosis – Variation might point to relative success in managing diabetics.
c) Admissions for asthma – Asthmatics shouldn't be admitted so variations might point to relative success in managing asthma.
d) Abdominal CTs for ER patients with nonspecific abdominal pain – Variation might point to deficiencies in clinical judgment or failure to adhere to clinical guidelines.
e) Returns to the operating room – Variation might point to clinical deficiencies.
f) Days of psychiatric boarding in the ER – Would provider valuable information for the Commonwealth.

We are not suggesting that these measures, or others like them, should be used as an indication of good or bad clinical care. Rather, that variations would identify areas for individual providers to explore.

11) Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

Providers across the state are actively engaged in developing and implementing strategies to reduce costs. We should not assume any one solution will solve the cost problem. Innovation should be encouraged. Many experts have told us "pay-for-performance" is the answer, and yet the largest hospital-based pay-for-performance program recently concluded that there was no evidence that pay-for-performance improved 30 day mortality (Medicare Premier Hospital Quality Incentive Demonstration). In our community we believe that our

PCMH approach is a cost effective strategy to improve care coordination and lower costs. In addition, our targeted approach, to clinical improvement strategies, ensures our resources are directed to solving problems rather than being absorbed into unnecessary overhead and infrastructure. Finally, patients must accept a role in the solution. This includes maintaining a healthy lifestyle as well as changing expectations about how their healthcare is managed.

AGO Questions for Hospitals

1.) **For each year 2008 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of carriers or programs included in each of these three margins, and explain and submit supporting documents to show whether and how your revenue and margins are different for your HMO business, PPO business or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.**

Summary Operating Margins FY08 through FY11 by Payer Group*

	FY08	FY09	FY10	FY11
Commercial	31,132,595	30,892,441	32,084,134	28,653,571
Government	(16,057,192)	(16,570,949)	(17,787,456)	(16,455,465)
All Other	(3,585,981)	(3,263,015)	(3,237,105)	(3,674,538)
Total	11,489,422	11,058,477	11,059,573	8,523,568

Percent of Business FY08 through FY11 by Payer Group

	FY08	FY09	FY10	FY11
Commercial	43.6%	41.8%	39.9%	37.7%
Government	52.2%	54.3%	56.1%	58.0%
All Other	4.2%	3.9%	4.0%	4.3%
Total	100.0%	100.0%	100.0%	100.0%

***These are estimated based on cost report information. The hosptial does not have a cost accounting system which is expensive to acquire and maintain and does not track operating margins by payor or payor group. These figures are based on a rough model specifically pulled together to answer the question posed. It relies on cost reporting step down statistics many of which have become somewhat obsolete over time. It is likely that cost allocations using this method are very different from what would be seen in a well maintained cost accounting system.**

The hospital does not collect data at the product type level. For example, all Harvard Pilgrim patients are classified as Harvard Pilgrim regardless of whether they are in a HMO, PPO or POS plan. The reimbursement to the hospital is the same under all products. The hospital currently has no capitated agreements. At one time the hospital had a budgeted capitation agreement for a portion of the population covered by one insurer with primarily upside risk.

Commercial includes: Massachusetts Blue Cross, Harvard Pilgrim, Tufts, Fallon, Aetna, United Health Plan, Rhode Island Blue Cross, and all other smaller commercial products.

Government includes: Medicare, Medicar HMOs, Medicaid, Medicaid HMOs, out of state Medicaid, Tricare and Commonwealth Care.

All Other includes: Industrial Accident and Self pay patients.

2) Please explain and submit supporting documents that show how you qualify, analyze, and project your ability to manage risk under your risk contracts (contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk), including per member per month costs associated with bearing risk (e.g. costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

The hospital currently has 2 (shared savings) risk contracts. Both contracts were effective as of 1/1/12 and have limited or no downside risk. We have not received any information to date to let us know how we are doing under these new contracts.

Additional risk would require the hospital to make significant investments in actuarial services, software, case managers and the like.
We do not think that is a prudent strategy given the size or our medical community. We have allocated significant resources toward getting an electronic medical record (EMR) up and running in the hospital and supporting the affiliated PCPs in getting designated as Level 3 Patient Centered Medical Homes by the National Committee for Quality Assurance. We are working on further integrating our patient's medical information across the continuum of care by setting up a Health Information Exchange (HIE) that can house data from any provider willing to invest in a compatible system. This will allow the physicians to best manage their patients and will ensure no duplicative/wasteful testing and treatment. We think that is the most cost effective way to slow the increase in health care costs for a service area of our size.

3. Please submit a summary table showing your advertising and marketing budget and costs for each year 2008 to present. Please explain and submit supporting documents that show the methodology you use to determine your advertising/marketing budget and costs.

Summary of Marketing/Advertising Budgets and Costs from FY08 – FY11
Compiled May 21, 2012

	FY08	FY09	FY10	FY11
Adv/Mktg	$354,791	$312,986	$329,654	$315,505*
Applicable portion of Salaries including benefits	$85,800	$ 92,400	$ 99,000	$105,600
Total	$440,591	$405,386	$428,654	$421,105

*more detailed information on next page

The above information is actual costs. There is a negligible difference between the budget and actual costs.

Marketing and Advertising Breakdown of Costs/Activities for FY11

Category	FY11 Expenditures
Multidimensional Corporate Campaign on Emergency Care Services, Maternity Services, Cancer Care Services, Technology, and Stability/Leadership	**$191,448.30**
Promotion of New and Existing Physicians/Providers	**$68,113.49**
Access to/Coordinated Care, i.e.: Call your doctor before using an urgent care center campaign	**$8,593.30**
Newcomers	**$6,624.23**
Public Service Campaigns, i.e.: Hunger, Hand Washing and Antibiotic Resistance, Stroke, and Colorectal Screening	**$14,401.07**
Annual Report and Sturdy Report	**$26,324.65**
TOTAL*	**$315,505.04**

* - total excludes % of staff salaries equal to approximately $80,000.

Sturdy marketing and advertising efforts are generally organized around five major themes: Corporate communications, physicians and providers, access to care, newcomer promotion, and public service/community benefits campaigns. One other large expenditure relates to the publication of two newsletters; the Annual Report and the summer Sturdy Report. Costs related to FY11 are delineated above. The distribution of monies for FY08 – FY10 was similar to FY11, the totals for which are found on Page 1.

Formula for determining advertising/marketing budgets: identify key institutional initiatives/priorities, i.e. programs and services to be promoted, public service campaigns, community events/community benefits activities, access to physicians, etc.; develop annual promotional plan; estimate promotion costs; and submit budget proposal to budget committee, which may be tweaked in the budgeting process.

4. **Please explain and submit supporting documents that show (a) trends since 2008 in the proportion of bed debt, as defined by M.G.L. c. 118G, § 1, you carry on your total business, (b) your understanding of the factors underlying these trends in bad debt, including but not limited to any role of health insurance plan design, and (c) any changes you have made to your debt collection policies, practices, or expectations in light of these trends.**

From Fiscal 2008 through Fiscal 2012 (projected), Sturdy Memorial Hospital's bad debt write-offs have increased 125%, as shown below.

	FY2008	FY2009	FY2010	FY2011	FY2012*
Bad Debt Write-offs	4,373,236	4,388,715	4,708,518	5,162,284	5,460,314
Increase year-to-year		100%	107%	110%	106%
Increase, aggregate					125%

* Projected

While the economy has likely caused an increase in bad debts during this time, we have also seen a trend towards increased patient liabilities (i.e., copayments, deductibles) in our patients with commercial insurance. In FY2008, patients who had commercial insurance were responsible for 6% of their total bill. In FY2011, the patient responsibility had increased to 9% of the bill. In addition, during that same time period, the percent of these patient liabilities that were written off increased from 32% to 37%. (It is also important to note that the percent of these patient liabilities written off in FY2006 was only 22%).

Throughout this period, the Financial Counselors in our Credit and Collections Department have continued our practice of working with patients to help them qualify for available financial assistance programs, including state, federal, and hospital based programs, and they have worked with them to develop reasonable payment plans for their patient responsibility.